APPLICATION / DECLINE / RECOMMENDATION FOR DENIAL FOR NON-COMPLIANCE

State Form 51362 (R2 / 6-06) / BCC 0095

Date (*month, day, year*)	ID number	☐ Center ☐ Home ☐ Ministry	County

Check one:

- ☐ New Provider
- ☐ Current CCDF Provider
- ☐ Refusal to participate; Current CCDF Provider
- ☐ Refusal to participate; Not a CCDF Provider

Reason for refusal:

Name of provider	Telephone number ( )

Address (*number and street*)	City, state, and ZIP code

Date of 1st visit (*month, day, year*)	Date of 2nd visit (*month, day, year*)

Date missing documentation due (*month, day, year*)	Date reminder call or notice (*month, day, year*)

Insufficiency (*check all that apply*)

- ☐ **A** *No response or packet not complete (Providers currently receiving CCDF funds only.)*
- ☐ **1.** Smoke detection / fire alarm and suppression
- ☐ **2.** Fire extinguisher
- ☐ **3.** Exits
- ☐ **4.** Fire drills
- ☐ **5.** TB tests and results / Health Assessment
- ☐ **6.** Written plans for _____ (*indicate type*) / Posted
- ☐ **7.** Training in _____ (*indicate First Aid or CPR*)
- ☐ **8.** Hot and cold running water from an approved source
- ☐ **9.** Working telephone
- ☐ **10.** Inaccessible _____ (*indicate firearms or poisons*)
- ☐ **11.** State central registry check for _____ (*indicate provider, employee or household member*)
- ☐ **12.** Written policy / Limited criminal history check _____ (*indicate provider, employee or household member*)
- ☐ **13.** Random policy / Drug test results for _____ (*indicate provider, employee or household member*)
- ☐ **14.** Immunization records
- ☐ **15.** Written policy for _____ (*tobacco, unintended substance use, illegal substance, alcohol*)
- ☐ **16.** Continual supervision of children
- ☐ **17.** Training in safe sleep practices, approved by the Division

Additional information (*i.e. calls, reminder letters, clarifications, etc.*):

Signature of provider	Date (*month, day, year*)

Signature of consultant	Date (*month, day, year*)

Attachments: Inspection form, supporting documentation (*i.e. drug test results, criminal history, central registry check, etc.*)

INTERNAL USE ONLY

Recommendation has been approved by:

Signature of FSSA supervisor	Date (*month, day, year*)

Signature of Educare consultant (*if applicable*)	Date (*month, day, year*)

Notice of order mailed (*month, day, year*)	☐ Faxed to Intake / VA ☐ Courtesy copies sent	Completed by

DISTRIBUTION: White - BCC; Canary - Provider